The family doctor in Canada. Part IV: his earnings

By David Woods

Annual income twenty pounds, annual expenditure nineteen nineteen six, result happiness. Annual income twenty pounds annual expenditure twenty pounds ought and six, result misery.

Finance has become a considerably more complex matter since Mr. Micawber offered those simple equations, and even that improvident fellow would doubtless have been "good for more" — as the loan company ads say — in today's live-now-pay-later economy.

Nowhere, it seems, is income a more complicated and emotional issue than when doctors are the recipients. In Canada, particularly since medicare, physicians' earnings have come under constant scrutiny and considerable criticism, and questions continue to be asked — by governments, by the press and by the public — about how doctors should be paid and how much.

Such questions are, in my view, entirely legitimate and properly democratic. After all, the majority of physicians today have only one paying customer — government — and, even though most of them are still entrepreneurs in the strictest sense, many of the risks associated with unadulterated free enterprise have been removed from modern medical practice.

Today's practitioner knows he will be paid reasonably promptly in coin of the realm. He will not be paid, as once was the case, belatedly or in apples or eggs, or not at all.

It should be noted here that much of the discussion about physicians and methods of remuneration relates to the profession as a whole, not merely to general practitioners. Obviously, such matters as income (gross, net and disposable), taxation, methods of payment and approaches to negotiation will apply as much to family physicians as to other segments of the profession. However, there are, as we shall see later, aspects of *how much* GPs are paid in relation to other physicians — and discussion about methods of remuneration that set the GP apart from his colleagues in other disciplines.

Knowing the score

The issue here seems not to be whether government, which pays the health care pipers, is entitled to call their tune; rather, it is the danger of producing shrill, discordant notes because neither the payers nor the players really seem to know the score.

And it's mainly emotionalism about physicians' earnings that produces the cacophony. Those incomes, even though they account for only about 19% of health care costs, are the most visible — and perhaps the most vulnerable — when governments, rightly concerned about Canada's current $11 billion annual health bill, seek to make economies.

The statistics show that the average physician earns about $45 000 net per year. This refers to the active, fee-receiving MD dealing directly with patients, and not to those who have traded their stethoscopes for the more cumbersome apparatus of bureaucracy or are in other salaried administrative posts which generally pay much less, and, if they were included, would tend to lower that average figure.

Since it has been shown that practising physicians put in a 55- or 60-hour work week, this income boils down to an hourly rate of about $15 if you allow its recipients a 2-week (unpaid) annual vacation.

"Wow," says the man in the street. "Those guys take less than 2 days to earn what I have to sweat for a week to pull in. They're cleaning up."

"Fifteen bucks an hour," says the physician. "When did you last get a plumber or a TV repairman to work for that kind of money?"

And so it goes.

The man in the street (who shouldn't be in the street anyway, but in the library checking his facts) has ignored the fact that doctors spend upwards of 9 years in education after high school and don't start earning any significant amounts of money until they're approaching 30 — or in some cases even older.

The doctor, on the other hand, has conveniently forgotten that the poor old plumber's housecall fee is gross, not net, and that he may have taken an hour to get from his place to yours.

The M in the S, especially if he's still there, will probably be quite unaware that physicians in Canada may not incorporate; the doctor is possibly equally oblivious to the fact that his TV repairman collects only about three quarters of what he actually bills his customers.

So far as physicians' incomes are concerned, let's return to the score. *Pianissimo.*

The figures

Taxation statistics from the Department of National Revenue show that, between 1961 and 1971, *gross* annual incomes for MDs increased from $35 693 to $61 516; during the same period *net* income rose from $23 818 to $42 624, and *after-tax* income from $17 236 to $28 371.

During that decade, Canada's physicians gained an increase of 64.6% in their income after taxes. This compares with 84.3% for dentists, 68.9% for lawyers, and 44.2% for accountants.

Recently, even the man in the street has stopped bandying about the gross incomes of physicians as the illustration of their being, so to speak, grossly overpaid. But even the

Media often portrays profession as money grubbing

more-usually-quoted net figures do not take into account the self-employed person's considerable expenditures in surrounding himself with the fringe benefits normally provided by employers to their salaried personnel: such items as retirement savings plans, paid vacations and insurance against disability and loss of income.

While increases in doctors' incomes are not out of line with those for other professions, one indisputable fact remains — actual earnings are consistently, and considerably, higher. Compare, for example, the 1971 net average incomes of dentists ($24 308); lawyers ($25 195) and accountants ($16 786) with the $42 624 figure for MDs. And all these professions are made up largely of self-employed people who pay for their own fringes.

Perhaps this is entirely as it should be. After all, one's health is patently more valuable and important than one's legal or financial status. Certainly, the public does not appear to begrudge the *individual* doctor his high income, and, as the president of the Canadian Medical Association put it recently, "Most patients offer the highly personal opinion: 'My doctor is a great guy, he probably makes a bundle of money, but when I consider the hours and the way he works, the training and experience he needs, the job and responsibility he has to carry, I think he deserves every nickel of it'."

That patient, Dr. Bette Stephenson went on to observe, becomes less charitable when considering the medical profession as a whole, using words such as money grubbing, demanding and rapacious.

If we can accept that those professionals trained to look after our health merit greater rewards than those whose business it is to save us from penury or prosecution, we are left with a number of unresolved problems.

Why, for example, are the average net earnings of dentists lower than those for *any* medical specialty? And what of the nurses and the physiotherapists?

Then there is the matter of the enormous variation in income among the various branches of medicine themselves — from a high (1971 net average) of $55 292 for orthopedic surgeons to a low of $34 426 for psychiatrists. Whose wisdom decrees that bone care is worth so much more than brain care? And who decides that the average net income of general practitioners shall be lower than for all specialists except psychiatrists?

Finally, there's the titillating question about *how* to pay.

The ancient Chinese paid their physicians only when in good health; payment stopped during illness. Much as the federal and provincial ministers of health might like to adopt that approach, there seems little likelihood of its coming about, despite the sentiments expressed by Marc Lalonde in his little black and white and avocado green book, "A New Perspective on the Health of Canadians".

In it the minister trains his glasses (rose-tinted ones, some would suggest) on the current health care scene and advances 76 proposals for improving the situation. In essence, his message is: "Patient heal thyself. Because if you don't, governments could go broke trying to do it for you."

Well, how should Canadian physicians be paid?

Choices in the West

The occidental options appear to be fee for service, salary, capitation or some amalgam of the three.

Fee for service, the traditional payment mechanism for Canadian doctors, has, despite its many detractors, certain virtues: it allows a measure of professional control and dignity; it offers some incentive for work above and beyond the call of duty; it fosters the feeling, if not the outright fact, of entrepreneurism by allowing physicians the option not to become civil servants completely; it has the kind of class that enabled professionals in Britain to invent their own exclusive and largely fictitious currency — called guineas; last, but most important, it may well be the cheapest method of payment for those who actually foot the doctor's bill.

Dr. David Road, one of 10 physicians who resigned in late 1973 from a Regina community health clinic that operated on a global budget arrangement, said at the time: "When you look at health care payment mechanisms around the world you can't help concluding that fee for service is still the most effective method."

The danger, as Road sees it, is in shifting prematurely to other forms of payment. He believes that it is easier to control costs — which are going to go up anyway — in a fee-for-service arrangement; moreover, he claims that FFS encourages freedom of choice for both physician and patient: the doctor is responsible primarily to the patient and not to a third party. Once that responsibility moves to a third party, Road said, "the patient no longer has redress. If that trend continues we shall have more ombudsmen than physicians."

If doctors on salary

In an article in *CMAJ* (Nov. 3, 1973) another physician from Saskatchewan, the cradle of "socialized" medicine in North America, asserts that if doctors went on salary the cost to public funds would increase by 97%.

To back up this seemingly extravagant argument, Dr. M.A. Baltzan said that, with an 8-hour day, 5-day week, with overtime at time-and-a-half or even double or triple time, with the "accepted" 4-hour charge for housecalls

(remember the plumber?), with 4 weeks' paid vacation, with fringe benefits at 14 to 17%, salaries would be an expensive proposition.

In fact, on these bases, Baltzan calculated a starting salary (worked out at a rate of $12 per hour) of over $40 000 per annum before overtime and other incidentals — and projected that physicians would be 18% better off on salary than on fee for service.

Baltzan had even gloomier news for those brave enough to pick up the tab. "Given the public's desire to spend sufficient time with the physician," he wrote, "the contract might require 30 min/patient. If this were the case, allowing for patient movement, dictation and coffee breaks, the physician would see approximately 3500 patients a year in regular hours."

Since, he went on, the Saskatchewan doctor sees 6000 to 7000 patients a year there would be a need for at least 75% more doctors.

Refuting these arguments in a subsequent issue of *CMAJ*, a literate, and presumably salaried, doctor of philosophy, Nathan Kroman, said they were confused. He noted that Baltzan had concocted a chain of assumptions and equivocations and concluded that in the growing confrontation between the medical profession, the public and governments, physicians will continue to remain at the top of the earned income ladder regardless of how they are paid. Kroman also made the interesting point (here comes the plumber again) that "skilled tradesmen are paid to be productive but physicians are currently paid to *try* to be productive... they get paid whether they produce the results desired by the buyer or not. We get no warranties when we consult our physicians."

There is an argument about salary that applies especially to the family physician. It is that the fee-for-service system actively discourages him from offering one service that he's especially trained to provide — counselling.

But counselling takes time. Does the GP take 10 minutes to prescribe a dose of Librium, or does he spend three times as long — for the same fee — to attempt to get to the root of the patient's anxiety?

It is perhaps in areas such as this that the system, not the practitioner, is at fault. In this context, it is naïve to suggest, as the *Toronto Star* does in an editorial (Jan. 11, 1975) that medicine attracts so many young people because doctors are so well paid. Perhaps, says the *Star* it's time to "have a look" at physicians' incomes in relation to those of other Canadians.

A disaster

So far as capitation as a means of payment is concerned, there are, according to Dr. Jan Brandejs, director of the Canadian Medical Association's department of research and development, some instances in which it might work reasonably well. In general, he feels that these are pretty much confined to small homogeneous populations where it's possible to retain some control, and that outside of these, capitation has been "a disaster". It creates a situation, he says, in which patients "shop" for physicians, and it also tends to encourage, if not exactly sloth, easy-going physician habits of practice. A highly mobile population, he believes, further compounds the problem unless, as has happened in Denmark, the government actually requires patients to register with one particular doctor; if they go elsewhere, they're charged for doing so. Brandejs concedes that capitation might be effective in, say, Canada's North but in general feels that it is the most unwieldy and most open to abuse of the various payment options.

However, as Dr. R.A. Armstrong noted in a paper on methods of physician remuneration in Canada, "... while capitation does not appear to be a very promising system for remunerating individual doctors or groups in competitive practice under current Canadian conditions, it may indeed have a very useful application in helping to promote rationalization of the health care system when employed at a different level."

Armstrong suggests that federal fiscal contributions to the provinces for medicare are a form of capitation, and provinces might consider making capitation payments to regional organizations in respect of hospital and medical services.

This, says Armstrong, would have the effect of forcing doctors to pay more attention to the costs they generate and regional authorities to think carefully before approving duplication of underutilized special services. It would also, he points out, promote the development of alternative approaches to institutional care with particular emphasis on ambulatory care in the community.

In all this discussion, one has to separate the emotional from the practical aspects of paying for personal medical services. The facts are readily available; the time has come to make proper use of them. As former CMA president Dr. Peter Banks has noted: "This avalanche of figures and the expected and unexpected facts and trends that are uncovered provide an inexhaustible source of morbid professional introspection and self-flagellation."

Taking some of these facts — the ones Micawber was so concerned about — Dr. Bank's successor, Bette Stephenson, has quoted some figures from the 11th annual report of the Economic Council of Canada about the increase in disposable income for Ontario physicians. In 1969, she says, this was 6.5%, or 2 percentile points less than for the average Canadian; in 1970, it was 6.1%, the same as for the average Canadian; in 1971, at 6.7% it was almost 4 percentile points less than average; in 1972, it was 6.2% compared with a whopping 12.2% average increase; in 1973, she said, the average Canadian's disposable income was up 13.8% while that of Ontario MDs increased only 6%.

A factor in this is that inflation has brought with it increases in physicians' costs of practice that are estimated to reach 50% of gross earnings for 1974.

While civil servants in Ontario, for example, are demanding 60% increases — and getting over 20% with hardly a murmur of protest from the public — the news that doctors in that province might ask for *gross* payment increases of around 14% (they received no increase in 1972 and 1973; 7.75% in 1974) generated cries of concern and anguish.

The self-flagellation Peter Banks refers to, if it is justified at all, should not be as a result of comparisons, odious at best, with other professions and trades (construction trade, he points out, increased its earnings 135% between 1962 and 1972; physicians had less than half that increase); but rather should be over discrepancies in earnings within the medical profession itself.

Living with it

The lifetime earnings of general practitioners, says Banks, amount to an average of $950 000; of medical specialists $986 000 and of surgical specialists $1 086 000. "These figures", he says, "we can live with, as they reflect increased training and increased stress. But there are within the profession certain groups, often not those that take the prime responsibility or do the most difficult work, who earn considerably more than their colleagues." Banks says that this differential — sometimes more than one third more — cannot be satisfactorily explained, and he urges some reconstruction of the fee schedules.

But *can* we live with these figures? Is there any valid

reason that the average GP's net earnings at just over $35 000 (1971) should be some 14% less than the average for the profession as a whole?

Today's family physician is created with specific extra training, and not merely by a lack of it. He is the portal of entry to the health care system — a pretty responsible role in which he can cope with upwards of 80% of the problems he encounters, referring the rest. He puts in long hours of work at approximately $12 an hour net.

Indeed, the cliché about time being money is very true in medicine, particularly in general practice. As Dr. Kenneth Clute says in his book "The General Practitioner" (1963):

> *The rendering of good medical care takes time* (italics his) . . . if society is not brought to realize that medical care is time-consuming, and particularly if those officials of government bodies . . . who may be more directly involved in setting rates of remuneration do not have a clear understanding of this, there is a danger that they will yield to the temptation to set a physician's remuneration at so low a level as to undermine the quality of his practice.

Clearly, that point has not yet arrived, and there are to my knowledge no physicians in this country of any persuasion who mooonlight as taxi drivers or whose wives take in washing to make ends meet. Or who don't know where the next meal is coming from.

However, the redistribution of wealth, like the practice of medicine, also takes time. And if the Ontario situation is any guideline, one does not have to be an economic genius to see that a few years of lower-than-average annual increases, sharply escalating expenses, and rampant inflation will gnaw away at physicians' incomes.

The whole matter of remuneration for doctors is a far less genteel business in Canada today than it was in pre-medicare days. Provincial divisions of the CMA have realized that bargaining with governments has become a way of life. Strikes have been carried out or threatened.

In general, though, says research director Brandejs (a PhD in industrial and systems engineering), attempts at negotiation have been characterized by guilt and overcaution on the part of physicians. Government has more economic experts than medical associations do, he points out, so the negotiations tend to become somewhat lopsided. Worse than that, there usually aren't enough facts on the table when the discussions do take place, and there is also a certain public relations lag to be overcome: for example, few people question the $50 000-odd salaries of airline pilots. Somehow there is an acceptance that their training and responsibility merit that kind of income. But collectively at least, physicians don't appear to have generated that sort of public understanding.

Tom Dempsey, a young economist at the CMA, has an entirely unemotional computer which shows that an inflation rate of 12% would in fact turn the Ontario Medical Association's proposed 4% increase into an actual loss of 15½% in disposable income. What Ontario physicians would need is a 23 to 24% increase in gross income just to stay ahead of inflation.

Wrestling match lost

Obviously, of course, inflation does not affect physicians only; it erodes all our incomes, and nobody is apparently more aware of that than Canada's elected representatives who, having promised (in 1974) to "wrestle inflation to the ground" are now (in early 1975) asking for 50% increases to cope with the body blow they have been dealt by inflation.

But the point is surely that, as nations and governments and individuals are in the business of redistributing wealth, why should any one group be any more equal than any other?

What it boils down to, says Jan Brandejs, might well turn out to be clout — nothing more nor less. In which case the medical profession is going to have to go to work on its notoriously weak financial expertise and perhaps even to make more militant that 60% of the profession that remains blissful in its ignorance of what's happening to its earnings.

So far as discrepancies in income within the profession are concerned, it is only hard facts that will redress the balance here also. That doesn't mean complete equalization since one has to take into account, for example, the neurosurgeon's comparatively short working life.

To some extent, the expected oversupply of physicians predicted over the next few years will exert its own influences on earning. The major urban centres will become increasingly inhospitable to practitioners considering practice there, and the so-called market forces will go to work to persuade MDs to practise in less populous, and less popular, areas. Government incentives to their doing so may no longer be necessary. (For extensive discussion on medical manpower, see the four articles which appear under The Political Process section in this issue.)

Whether physicians choose to call their provincial medical representatives associations or unions hardly matters. What is important is that, to retain some measure of professional independence, they must have a restrained and responsible hand on the government's pursestrings.

That doesn't mean a restraint based on the self-flagellatory approach Dr. Banks refers to; that responsibility falls short of the swashbuckling "those jokers can't operate medicare without us" expressed by the leader of the powerful Quebec specialists' union a year or so ago.

The medical profession *en bloc* will make its future financial case only by clear and forthright discussion of the facts with public and government.

David Woods continues his series in the next issue of CMAJ.